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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF OHIO

EASTERN DIVISION

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SARAH ARONSON, M.D., Plaintiff, v. UNIVERSITY HOSPITALS OF CLEVELAND, Defendant.

CASE NO. 1:10-CV-00372
JUDGE BOYKO

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DEPOSITION OF DAVID WALLACE, M.D.

Thursday, December 23, 2010

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The deposition of DAVID WALLACE, M.D., a Witness herein, taken by the Plaintiff as if upon examination under the Ohio Rules of Civil Procedure, before me, Mary C. Peck, a Stenographic Reporter and Notary Public within and for the State of Ohio, at the offices of Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Key Tower, 127 Public Square, Suite 4130, Cleveland, Ohio, commencing at 9:00 a.m., the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiff:

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ALSO PRESENT

Sarah Aronson, M.D.

Matthew Norcia, M.D.

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EXHIBITS

DAVID WALLACE, M.D.

called by the Plaintiff for the purpose of examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

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EXAMINATION OF

DAVID WALLACE, M.D.

- - - -

BY MR. GORDILLO:

Q Good morning.

A Hi.

Q Would you please state your full name for the record?

A David Alan Wallace.

Q As we go along today, how would you like me to address you?

A David is fine.

Q Okay. David, would you please state what your home address is?

A 30907 Hilliard Boulevard in Westlake, Ohio.

Q Does anyone else live there with you?

A My wife.

Q What's your wife's name?

A Bonnie.

Q Anyone else?

A No one else.
Q David, have you had your deposition taken before?
A I have.
Q Have you testified as an expert witness before?
A I have not.
Q Okay. How many times have you been deposed before?
A I think twice.
Q And do you know what the lawsuits were about that you were deposed in?
A I believe I was deposed -- yes. I was deposed for a lawsuit in which I had prescribed a patient some medication and the patient overdosed on a bunch of different medications, including the medication I prescribed.
Q That was one case. Were you deposed in some other case, too?
A I was deposed in another case in which I gave anesthesia, and the patient had, weeks later, the need to come back for surgery and had complications during the hospital stay after a second surgery, so I was deposed in relation to that case.
Q Other than cases involving allegations of negligence, medical negligence, have you given any other testimony?
A I don't believe so.

Q Who is your current employer?
A UHMG.
Q UHMG, is that an acronym?
A It's University Hospitals Medical Group, I believe.
Q And is that your only employer right now?
A No.
Q Who else employs you?
A I work part-time for Columbiana Anesthesia.
Q Is that a practice group?
A There's a hospital in East Liverpool, Ohio that I occasionally work at, just some call coverage.
Q What is that hospital?
A East Liverpool City Hospital.
Q And presumably Columbiana has a contract to provide services to the East Liverpool City Hospital; is that right?
A They're the providing group for the hospital's anesthesia services.
Q Okay. Do you have any other employers right now?
A I do.
Q Who else employs you?
A I work for Jenson Board Prep.
Q What do you do for Jenson Board Prep?
A I teach oral Board preparation courses and pain preparation courses.

Q Do you have any other employers right now?
A I don't think so.
Q Okay. Tell me what you do as an employee of UHMG.
A I'm an anesthesiologist. I practice clinical anesthesia, and I'm the Vice-Chair of Education, although that title is technically with the School of Medicine. We're co-appointed faculty to Medical School and staff of the hospital, so I'm also the Residency Program Co-Director. And I'd say those are my primary responsibilities.
Q So you're the residency co-director for the Anesthesiology Residency Program at University Hospitals of Cleveland; is that right?
A It's University Hospitals Case Medical Center. It's actually Case Western Reserve University, University Hospitals Case Medical Center. That's the formal name for our Residency Program.
Q How long have you been the co-director of that program?
A On January 1st, it will be ten years. January 1, 2011, it will be ten years.
Q As the residency co-director, were you responsible for supervising Doctor Sarah Aronson when she went through the program?
A I had part responsibility both as a faculty doing

clinical anesthesia cases, and I had responsibilities as her program co-director.

Q All right. Tell me what your responsibilities were as a faculty member relative to Sarah Aronson.

A She was a resident training in our program, and in order for her to get Board certified during -- or to complete her program, she had to do clinical anesthesia cases. She's not allowed to practice anesthesia without the supervision of anesthesiologists overseeing that and taking responsibilities for patient care. So I was a faculty involved with her as a resident in training.

Q And what were your responsibilities relative to Doctor Aronson in your capacity as co-director of the Residency Program?

A Well, Doctor Norcia and I took over as program co-directors on January 1, 2001, and at that time, we sort of delegated responsibilities, and from my recollection, there was about 20 different areas that we decided someone should be responsible for, so we sort of divided those up, and some of those responsibilities that I primarily was responsible for was things like doing the scheduling for residents, clinical schedules. I did case log coordinating. I dealt with various problematic resident issues. I'd

say those are some of my primary roles.

Q Can you recall any of the other roles that were divided to you among those 20, or so, topics?

A There were some roles that we shared. Like, we would do resident reviews and we would essentially do those together. We were responsible for maintaining our accreditation with the ACGME, and I was responsible for a lot more of the computer work than Doctor Norcia, so I did a lot of word processing and Excel Spreadsheet processing. I was responsible for our residents -- I was partially responsible for our residents' participation in the Midwest Anesthesia Residents Conference, which is held usually in March or April, so I did our residents' abstract proofing, their Powerpoint proofing for their projects. I did their poster proofing for their projects, and I have had a lot of experience in editing -- doing editing on Powerpoint for poster presentations, so I was primarily responsible for those types of things.

Q Were there any other areas that you were primarily responsible for?

A I'm sure there were. I don't remember the complete list.

Q Other than the resident reviews and accreditation, were there other areas that you shared with Doctor

Norcia?

A Yes. We did education planning together, curriculum developments together. We worked on ACGME accreditation tasks together. We were involved with our ACGME site visit for re-accreditation together. We were involved with going to meetings to prepare us for ACGME rules, learning the ACGME rules together.

Q Anything else?

A We planned graduation events together. We put on a graduation program for the residents together. That's most of what I can think of right now.

Q Okay. When you mentioned that you did most of the computer work, I think you said -- you gave an example of working with Excel Spreadsheets. What kind of information were you working with in connection with the computer work that you did?

A I would put together lists of residents if we needed to have them for organizing activities or events that were needed to be done. I would -- a primary thing I would do with Excel is managing residents' schedules and helping with both intern and our anesthesia residents' 36-month schedule.

Q And with respect to the work that you and Doctor Norcia did concerning education planning, can you tell me more about what that work was?

A Doctor Norcia and I would meet with the residents on a periodic basis. We would generally -- the format was first speaking to the interns, then the CA1s then the CA2s and then the CA3s and getting specific feedback from the different classes with all in attendance as a group. And based on the feedback, we would evaluate any pluses that were said or negative things that were said to see if we should continue doing some of the different types of things that we did or see if we could change them or alter them.

Q Did education planning involve any one-on-one meeting with residents or interns?

A I wouldn't say that that was a specific thing for curriculum change, no.

Q And you mentioned education planning. I want to be clear, because I'm going to switch in a second. So you would not say that one-on-one meetings with the residents was part of what you did in the context of education planning; is that right?

A Well, we met with all the residents individually, and many times throughout the years we would ask them for their opinions, and that may, again, give us some more input or influence some of the things that we did. But we would have education committee meetings, and we would take things that we would get feedback

from the residents, and we have an education committee, so we would provide information to the education committee, but that could come from anyone; faculty or residents or other staff. We would take inputs from everyone.

Q What did you do with Doctor Norcia with respect to curriculum development?

A We first -- in January of 2001 when we took over, soon thereafter we made attendance to our didactics mandatory. Before that, it wasn't. So we felt it was important for people to attend didactics. It's also ACGME required, so that was consistent. We changed our -- over the years, we changed our curriculum on how we do things.

For instance, we used to have a three-year curriculum that would cover the complete curriculum in two years, so there's a 50 percent overlap. With time, we evolved to having a two-year curriculum and then a separate curriculum for our CA3s.

We changed the Journal Club format to make it a three-month long process for the learning process in putting the responsibility of selecting topics, selecting articles, and presenting articles on the residents' responsibility. So we changed the whole format of that. We started -- originally we started

something called Barash Club, which was assigning residents specific sections of a chapter to read every week, and then portions of the chapter they would write questions, submit questions to us, and then we would review the questions after our faculty gave the lecture or interactive discussion based on that topic. And we've done that for Barash and Stoelting's Book. And then we went back to Barash, based on resident feedback, then went to Big Blue, and then Morgan and Machale, and then we went back to Barash. Over the last ten years, that's the sequence of books that we've read based on feedback from residents and our education committee.

Q Do your responsibilities include counseling with residents about their own curriculum choices?

A I'm not sure I understand what you mean by curriculum choices.

Q Well, residents do have some flexibility in terms of what they want to focus their rotations on, right?

A So over a 36-month period within -- usually they start as -- a CA1 is a first-year resident, a CA2 is a second-year resident, and a CA3 is a third-year, so it's 12 months per year for the traditional track, and over that 36-month span, in the first two months, July and August, we rotate our residents through

different areas clinically just to get them sort of basic foundation skills. And during that period of time, they essentially take no call and they start off on a more one-to-one basis until they demonstrate they can perform independently.

During usually the second month, in August, is when I make up a 36-month schedule that is sequential, and I have 12 different residents with no name attached to it. So since we have 12 residents and Doctor Nearman our chairman wanted everyone's training to sort of be transparent or seamless, we have basically the same core rotations in curriculum for all the residents.

Out of that 36-month period, there's about roughly 30 months that are -- somewhere approaching 30 months that are core curriculum that everyone does, and then there's an average of about five or six months that there's some flexibility to making choices or decisions.

Q Right. And that's what I'm really asking about is that five or six months of making choices or decisions. Do you counsel with residents about those choices or decisions?

A Well, I would say usually -- I'm not sure if the word counsel is -- I would say I negotiate with the

resident.

Q Okay. Why do you say negotiate?

A Because the way our program is set up, most residents that are on a flexible month need to be on an OR or an OB rotation, and based on what their interest is, then we can't have too many residents on any one service because it dilutes the experience for the core residents' rotations, and if someone wants to do something, for instance, like research, we have guidelines on what the requirements are for someone to do research.

So they have to submit a proposal, which usually is just like a paragraph of what they want to do, and then we talk to the education committee about that for their approval of that, and part of that would then include one day in the operating room -- one day in the operating room a week during that period. And that can be anywhere -- we've had anywhere from one month to, I believe, three months. I don't think we've had anybody do anything longer than three months.

The ACGME allows up to six months in any one specific area after your core rotations, and we can't have -- just from a staffing standpoint, we can't have five or six people all in the same month doing

that. It just makes it an inequity to provide service and the amount of calls that the residents do. It puts an extra burden on other residents. So based on the context of what they want to do, I try to see what all the other residents are scheduled for and then try to make a more logical decision of when someone can do a certain rotation.

Q Do you find that there are certain rotations that tend to be more popular or more in demand by residents?

A Yes.

Q Which rotations are those?

A I would say that a more popular request is for doing some pain, extra pain. We have a lot of requests for residents to do regional anesthesia. We have a fair number of requests to do extra obstetrics or pediatrics. We have a lot of requests to do more advanced cases, but not a specific area, and then we've had people wanting to do more cardiac, more thoracic, more neuro. I would say those are the primary things. We've had an occasional resident want to do some ambulatory surgery based on where they were planning on practicing. So I'd say those are the primary interest areas.

Q So are these the areas that you most frequently find

yourself having to negotiate so you can balance the number of residents in the rotation at one time?

A Well, essentially any month that I would consider a float month or a flex month, I negotiate everyone, because I have to have the residents declare what they want to do, and some of them say, put me in anything, and so that's fairly easy to accommodate. Sometimes they say they want to do a specific rotation, or I'll tell them after I have all of the other residents scheduled for that month, the month to come, I'll say, these are the areas that are open, what would you like to do? And they could suggest that.

Sometimes they have some goals that aren't really assigned to a room specifically, like they want to do a difficult airway management month, which they can do. They can be assigned to many different rooms or nothing real specific for service. But every month I have to put down their name, and we have something called a magnet board, which has one name for everybody in the department, and their name has to go somewhere. No matter what it is, their name has to go somewhere on the board; whether they're on vacation, whether they're on call, whether they're post-call. Everyone is identified to be somewhere.

And in the -- around the middle to the end of the month prior, I have to make a schedule and send it to the scheduler to put into our electronic system, and I have to place every resident name somewhere.

So I'll say, essentially always I get feedback from the resident to where they want to be placed if they're not assigned to one of their core rotations. So every month if they have a flexible or float month, it has to be negotiated. And if they give me enough notice, we to try to optimize them to be in a month where they have flexibility when there's not a lot of other people in that area or someone is taking vacation and won't be on a certain service, then that would give them more of a primary selection for cases, for good cases.

Q And you say flexible or float month. Is a flexible month and a float month the same thing?

A Not exactly.

Q Okay. Tell me what the differences are.

A The flexible months tend to be earlier in -- before the core rotations are done, and there are certain rotations that we can have more than one resident in, but all the residents still get assigned to it.

For instance, we have six ambulatory surgery operating rooms and we have some that are related to

orthopedics generally and some that are related to laparoscopic types of surgeries. So they have to do -- we can assign multiple residents when they are in a flex month, because everyone has to rotate through there. In the main ORs, we have a room that we do a lot of bariatric cases, so that's a good general anesthetic room. It gets them good airway management experiences and dealing with basic cases where there's not a lot of turnover, and we have a transplant room, a second vascular room, so everybody rotates through those types of rooms. We have a secondary, not a primary, ENT room and plastics room. We rotate all of our residents through.

So on any given month, if three residents that haven't completed their core rotations have flexible months, I can go from that sort of sub-pool of rooms and make an assignment for them.

As the residents complete their course and then towards the end of their residency have flexibility, then that's more of what I consider a float month where if they met the requirements, then they can just be assigned to whatever they what, whatever their interests are, to sort of gear them toward what they might anticipate they will be doing or what they want to do more because they may not be able to do it

later or to meet some of their requirements, but that has more options, I would say, in some regards.

Q Are there certain rotations that you find that are less popular or the residents don't seem to like?

A Let's see. As far as residents go, I've heard residents sort of joke about neuro anesthesia and about taking their vacation when they're on their core neuro rotation, and I've heard residents joke about pediatric anesthesia, but we do -- in the core rotations -- because we have Rainbow Babies and Children's Hospital, because of the Children's Hospital, we actually in our curriculum have set up three months of pediatric anesthesia when only two months are required, so they do a lot of pediatrics, and some residents may not go out into practice and do pediatrics, so they may not have as much of an interest in that. Some people like obstetrics. Some people don't like it. It's a dipolar service, I would say. So I would say those are the primary ones that I've heard people may not like.

Q In June of 2009, you had a meeting with Sarah Aronson about her performance. Do you recall that?

A I do.

Q Tell me what you recall about that meeting.

A I remember that we were -- that I was on call the day

before, and in order to meet with Sarah, I stayed post-call, and Doctor Norcia and I met with her in -- I believe it was the conference room next to the Mather Operating Room Control Desk.

Q Who ordered you to the meeting?

MR. BIXENSTINE: Objection.

A No one.

Q You said that you were ordered to meet.

A No. In order to meet.

Q I'm sorry. In order.

A In order to meet with her, I stayed after call.

Q Who had decided to schedule that meeting?

A I guess it would have been Doctor Norcia and myself.

Q And why did you choose to schedule a meeting on that particular day?

A Because the end of the six-month period for which we report to the ABA the Clinical Competency Committee report, that was going to be coming due, and I can't remember the last time we had met with Doctor Aronson, but we needed to review her evaluations, so we decided to meet with her.

Q Did you meet with any other residents that day to review their evaluations?

A No.

Q Did you meet with any other residents the day before

to review their evaluations?

A I was on call the day before, so I didn't.

Q And did you meet with any other residents the day after the meeting with Sarah?

A I'd have to look at a calendar. I can't remember.

Q The reporting period that you mentioned would have been due in July, right?

A It would have been due by the -- I believe the last day in July.

Q Did you meet with all the residents toward the end of that six-month period? When I say all the residents, separately to review their evaluations.

A I don't believe we met with all the residents. From my recollection, although I'm not 100 percent sure, but I believe in the month of June, we met with the whole class of graduating residents. I think that was during that month period. And I actually -- I want to rephrase a question, now that you mention that.

When you asked me if we met with any other residents on June 4th, we may have met with some other residents in that time period, but I don't remember exactly the dates for those, but I believe we met with the whole graduating class in June prior to when they were going to graduate.

Q Before you had the meeting with Doctor Aronson, did you confer with Doctor Norcia about how the meeting would go?

A I don't know how I could have done that. I wouldn't know how the meeting would go.

Q Well, did you work with Doctor Norcia in any way to prepare for the meeting?

A I don't remember the details completely of the preparation for that meeting. I do remember that I had some documents that I brought with me to the meeting. I don't remember if Doctor Norcia had any, and I don't remember what we had prepared.

Q What documents did you bring?

A In that previous six-month period, I had worked with Doctor Aronson probably at least -- or had some type of interaction with Doctor Aronson at least four or five times which I felt was performance that was not acceptable, and so I had some supporting documents in relation to those so that I could present some detailed and specific facts related to those cases or incidences that had occurred.

Q So when you say the prior six months, are you talking about from January of 2009 to June of 2009?

A From January to June of 2009, yes.

Q And during that period of January 2009 before the

meeting on June 4, 2009, did you have conversations at all with Doctor Aronson to inform her of your concerns about her unacceptable performance on those four or five interactions?

A I believe I spoke to her about all of the ones that were related clinically, and there is one that was related to a day that I was coordinating the operating rooms and about her non-clinical behavior and I confronted her directly about that, but we didn't sit down and talk about it or review it later.

Q Did you share your concerns at the time of the interactions with Doctor Norcia?

A Could you say that -- I'm not sure.

Q Did you share with Doctor Norcia the concerns you had about Doctor Aronson's performance at the time the interactions occurred?

A Not at the specific time.

Q Had you shared them with Doctor Norcia before the June 4th meeting?

A I believe he was aware of all the incidences.

Q Why do you believe he was aware of them?

A Because I think I recall all the incidences, and I -- from my memory, I believe I spoke to him about her poor performance during all those incidences because of the nature of them.

Q Did you confer with Doctor Norcia about the documents you were going to bring to the June 4th meeting before the meeting?

A I believe I told him maybe in a generalized way about some of my interactions that he may not have known or remembered -- well, he knew of previous, but he may not have recalled what they were, but I told him that I was going to bring my documents related to my personal interaction with Doctor Aronson.

Then I had other documents from other faculty that had worked with her in that time period, and I had some documents from residents on interactions they had had, and I believe I also had the electronic evaluation tool that we use that are reports that are generated from that for a time period that was, I believe, from the last time we reviewed her to roughly that date.

Q Before the June 4th meeting occurred, had anyone told you that you were too emotional in the way you were evaluating Doctor Aronson?

A I don't believe so.

Q Had anyone told you that you were not sufficiently objective in the way that you were evaluating her?

A I don't believe so.

Q During the meeting, did you discuss with Doctor

Aronson her performance?

A Yes.

Q What did you say to her about her performance?

A Basically I had all of the different interactions that we had had, and at this point, she was past what would have been the normal date of matriculation for her when she first started in Clinical Anesthesia because she had received an unsatisfactory for the prior six-month period. And based on the evaluation information that I had, I told her that I didn't think she was probably going to get a satisfactory for the six-month period from January of '09 through June of '09.

Q Before you said that to Doctor Aronson, had you shared that opinion with Doctor Norcia?

A We had talked about Doctor Aronson's performance on many, many occasions whenever we would get some evaluation information, because at the end of the six-month period, for all residents, we have to fill out that ABA Clinical Competency Report, and in order to do that for someone to have a successful completion of that six-month credit, all answers have to be answered as a satisfactory. If there's a single one that's unsatisfactory, then the whole six-month period gets an unsatisfactory result.

And so in order for us to determine on an on-going basis how her performance was, we would discuss it, I'd say, on the occasions when we'd get more information.

Q Before the June 4th meeting, did you share with Doctor Norcia your opinion that you believed for the current reporting period Doctor Aronson was not going to be able to complete the period satisfactorily?

A I don't remember saying that to him specifically because we hadn't had the meeting yet. And one of the problems that I had with Doctor Aronson prior to the meeting after the events that her and I had dealt with occurred was that she was unable to explain her behaviors, and my perspective is that if she had an explanation for her behavior, then that would help determine whether things would be considered that she could be graded as satisfactory or not.

So without getting an adequate explanation, then I just go by the facts that I have and make my best assessment of what I think her progress is. But Doctor Norcia and I, we make our own independent assessment and then -- we don't just agree with -- I don't just agree with him and he doesn't just agree with me. We make our own assessments and evaluate all of the evidence and then come up with a

conclusion.

Q So as far as you know, the first time that Doctor Norcia would have learned that your opinion was that Sarah Aronson was not likely to complete that period satisfactorily was at the June 4th meeting?

A I can't say that's true. Because from my recollection, when an incident would occur and then I talked to Doctor Aronson and then she would have no explanation, my conclusion would be, this is not very good for supporting her to have a satisfactory.

But we don't -- we cannot make a decision until the end of the six-month period, and so we have to wait until we have all the information and we have to meet with the resident. And if a resident does something that I feel is not appropriate and they have a good rationale, then it's doing what I would consider the wrong thing for the right reason. But the problem I had with Doctor Aronson is she would give no reason, and at that stage in her career, an anesthesia consultant has to be able to at least have a reason for why they do things, in my opinion.

Q Did Doctor Norcia indicate to you in any way whether he agreed or disagreed with your assessment?

A On June 4th?

Q Yes.

A No. I don't believe he did, because we have to go through to the end of the month, so I just informed Sarah, because I believe in being more open about things, and I told her what my impression was. And it's not the final conclusion, because if someone -- you know, if a resident thought about something and came up with an answer the next day and said, well, this is why I did it, even though she didn't have a reason for doing things. But if that were the case, we have to go to the end of the period. It's graded for the whole six-month period.

So when the last day of the month comes and goes, then based on all the information, the decision on how to grade someone is based on all that six-month information. So on June 4th, it's not the time to make the final conclusion, you know, unless there's something so egregious that would fall into a different realm.

Q So you believed that on June 4th while you had the opinion that she was not satisfactorily completing her work, that she could change and in fact in that month make for the work to be satisfactory?

A I don't know if that's a true statement. I don't know if her changing -- you know, to say a performance from June 4th to the end of the month,

someone could do something that would make me believe that they go from an unsatisfactory to satisfactory.

My statement is if she could come up with explanations and reasons that seemed reasonable to justify what she did for the time up to that point, that would be a possibility. I just couldn't think of a reason why she did some of the things that she did.

Q Fair enough. Let me try it again then.

If she had come up with an explanation to you for her prior actions, that may have been able to change your mind about whether she had satisfactorily completed the work for the period that was going to end the end of the month in June?

A That would be possible.

Q Were your concerns about her performance in June the same types of issues that you had when she was rated unsatisfactory in January?

A No.

Q How were the issues different?

A Well, the issues -- the issues on June 4th; is that the question?

Q Right. The issues that were leading you to believe she was not going to be able to complete the January to July period satisfactorily, how were those

different from the issues that caused her to be unsatisfactory in the previous July to January period?

A Well, she -- from my personal experiences, just working with my personal experiences, she brought up some of the -- some core competency issues that were different than what had been -- what had led to her getting an unsatisfactory prior to that.

Q When you say core competency, are you talking about in the context of the six competencies laid out by the ACGME?

A Yes.

Q Which were the core competencies in terms of the ACGME was she showing deficiencies in in June of 2009?

A I would say systems-based practice was one. Patient care was a second. Interpersonal communication skills was a third. Professionalism was a fourth. I might even say that she demonstrated the result of the practice-based learning and improvement core competency -- she demonstrated the lack of that result or didn't demonstrate that she was learning based on her experiences. So I'd say at least those.

Q Well, that's five. What's the sixth one that she was satisfactory in?

A Medical knowledge is the sixth one, and I think she has what borders on extraordinary medical knowledge.

Q Did you believe that her performance deficiencies in June were more serious than her performance deficiencies that were rated in January?

A I don't know that I could answer that.

Q Do you know why she was able to successfully complete the program despite your opinion?

A I think I can answer that, but that's a big -- that's a -- can you be more specific in that question?

Q Sure. Let's start this way.

You agree with me she successfully completed the program?

A Yes. She graduated.

Q And she graduated despite your having the opinion in June that she wasn't going to be able to satisfactorily complete her last reporting period, right?

A That's correct.

Q But that's a requirement for her to successfully complete the program, that she complete the last period satisfactorily, right?

A Yes -- well, that's not -- well, the very last six months have to be satisfactory.

Q Right.

A Not necessarily that six months.
Q So if she was going to complete in August, she could have been satisfactory from August of the prior six months?
A No. What I'm saying is if she'd gotten an unsatisfactory for the period of January of '09 to June of '09, then the previous six months of unsatisfactory would not get satisfactory, and she would have to continue for another six months in order to bring the January of '09 to June of '09 unsatisfactory to becoming credit.
Q Right. But in any event, her last six-month rating period had to be satisfactory for her to --
A The last six months have to have a six-month satisfactory period in order to complete.
Q So if your opinion that she wasn't going to be able to complete the six months from January to June satisfactorily was correct, she would not have been able to complete the program; is that right?
A I don't know that -- I think the way you worded that, that's not true.
Q Let me try it this way: How could she have completed the program if she had been rated unsatisfactory for the reporting period ending in July of 2009?
A She couldn't have.

Q That's what I'm getting at.
A Yes. The last six months has to be satisfactory for a resident to graduate.
Q And you held the opinion that she was not going to be able to complete that period satisfactorily, correct?
A On June 4th, yes.
Q But she did complete the program satisfactorily, right?
A She did.
Q And she received a satisfactory rating for the period from January to July; is that correct?
A Correct.
Q So my question is: What happened that caused her rating to be satisfactory when you were of the opinion in June that it was unsatisfactory?
A Well, my opinion is just one person's opinion.
Q Okay.
A And the determination, despite what some people may believe, it's not my decision. It's Doctor Norcia and I discuss -- we look at the faculty input, others' input, residents' input. We also in this circumstance had input from Doctor Nearman, and I believe we had some input from Doctor Shuck to make the decision.
Q And the decision was made at about the end of July?

A I don't remember when her Clinical Competency Report was filled out, but generally speaking, it's towards the middle to end of July when those reports are filled out.

Q The report would have been due at the end of July, right?

A It's due by the end of July. I don't remember when it was actually filled out.

Q But presumably, you're going to fill out the form shortly before they're due, right?

A Well, I don't fill out the form.

Q Well, you're going to reach -- the program is going to reach whatever conclusion they reach about the resident's performance shortly before the form is due; is that correct?

A Well, the decision would be made after, in this case, June 30, 2009, and that interval between July 1st and -- well, I'll say at the end of June 30, 2009 to when the report gets filled out, sometime in that period is when the decision was made.

Q I understand. So is it fair to say that your colleagues; Doctors Norcia, Shuck, and Nearman, and the other faculty members of the Anesthesiology Program collectively did not agree with your assessment?

A I don't believe that's a true statement.
Q Well, did they agree with your assessment that she had not satisfactorily completed the reporting period?
A Well, if you're saying, did everybody in our department except for me agree that she should graduate, I don't think that you -- that that's a globally correct statement.
Q But it was the representation of the department that she had satisfactorily completed the reporting period, correct?
A Yes. Our program deemed that she had satisfactorily completed the program.
Q And you disagreed with that, didn't you?
A My personal opinion is that she did not do what I would expect of someone that should be ABA Board eligible. She did not meet what I would personally think was adequate to be a Board certified anesthesiologist.
Q And because you were too emotional and not objective enough, you were removed from the process; isn't that right?
A First of all, I wasn't emotional about the -- whatever you had just said. I wasn't emotional about it. I had scientific and objective evidence to base

my decision.

Q Were you removed from the process?

A Which process are you talking about?

Q The process of evaluating Sarah Aronson.

A Well, I was still in the capacity to evaluate her up until June 30th. That's the last of -- or, no. No. She was still -- no. I was still in the process of evaluating her. Yes. I was still in the process of evaluating her until the day she graduated.

Q Did you ever have a conversation with Doctor Shuck in which Doctor Shuck advised you that you should not be so closely involved in evaluating Doctor Aronson?

A I don't specifically recall what you just said as being correct.

Q Well, do you generally recall that what I said is correct?

MR. BIXENSTINE: Objection.

A Could you just tell me your question again?

Q Let me ask a different question.

Did you have any conversation with Doctor Shuck, the gist of which was to limit your involvement with Sarah Aronson?

A I may have had some conversation like that. I may have.

Q When did that occur?

A If I had that, I would think it would have been maybe in July or after July.
Q Not in June?
A I don't recall -- I don't recall it being in June because the decision was not made about her satisfactory or unsatisfactory performance for that six-month period. She hadn't completed that yet, so I don't believe that would have been when it was.
Q What did Doctor Shuck say to you?
A I honestly don't remember having a specific conversation like that. I don't.
Q Did you have any conversation like that with Doctor Nearman?
A I don't think I ever had a conversation like that with Doctor Nearman.
Q Did you consciously find yourself limiting what role you took with respect to Sarah Aronson in the Residency Program?
MR. BIXENSTINE: Objection. Do your best.
A When?
Q At any time.
A Yes. Could you just ask the question again?
Q Sure.
MR. GORDILLO: Could you read back

the question?

- - - -

(Thereupon, record read by Notary)

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A Well, I can remember doing what I felt was limiting my involvement by having her certificate prepared differently.

Q And how did you limit your involvement with respect to preparing her certificate?

A I had the place for my signature removed from that document.

Q Why did you make that choice?

A Because I personally still felt that because of her inability to explain her actions, which I thought were unusual or bizarre behaviors, that I couldn't -- I couldn't feel good about signing her certificate.

Q Let's take a look at a document that was previously marked as Exhibit 12. And David, any time I hand you a document, I want to make sure you take all the time you'd like to look over the document so you can become adequately familiar with it and let me know when you've had fair time to review it.

A Okay.

Q This is, as you see, an email string between Doctor Aronson and Doctor Shuck.

A Mm-hmm.
Q And in the middle of the three emails, you see that Doctor Aronson was asking Doctor Shuck to confirm her understanding of a conversation the two of them had on June 16th; do you see that?
A I do.
Q And part of that conversation that Doctor Aronson understood was that Doctor Shuck informed her that you were no longer a player, in quotes, and that he, Doctor Shuck, was going to remain in the on-going process. Did you see that part of her email?
A I do.
Q And do you see his response?
A His response?
Q To her asking about whether she's summarizing the conversation correctly. And his response is at the top.
A I don't see his response at the top.
Q Right. At the top he says, yes.
A Oh. Oh. I see. Yes. Yes, that's his response.
Q So she has accurately summarized that on June 16th, he informed her that you were no longer a player?
A Yes.
Q As you see this document, do you believe that you were no longer a player by June 16th?

A I'm not sure what no longer a player means.
Q Ever heard that phrase, no longer a player?
A I believe I have.
Q What do you think the phrase no longer a player means?
A What I envision -- I don't know. I envision a football team and someone is not playing. I don't know. They can't play.
Q Do you believe that as of June 16, 2009, you were described as being no longer a player with relationship to Sarah Aronson?

MR. BIXENSTINE: Objection.

A I don't know I can make a comment about that because, from my understanding, there were many meetings with Doctor Aronson and others, which I was not part of, and there were lots of things that were said. I have no idea. I wasn't there. I can't make a comment about it, and I don't understand what it means.

But my recollection today is that on June 20th, there's a -- we're not past the June 30th date, and unless I put this in some kind of context, like for instance, if on June 16th if Doctor Aronson had two weeks of vacation, or something, maybe I'd be considered no longer a player because we wouldn't be interacting together, but I practice clinical

anesthesia, and I don't recall what rotation she was on at the time, but I evaluate every resident. I see what they do, and I evaluate all of my residents, so I don't know what no longer a player really means. I didn't quit my job. It wasn't designated time for her to graduate at that point. She hadn't completed her six-month Triple C Report, so I can't make a comment. I don't know. On that date, I can't remember exactly what they were saying or if I qualified for what no longer a player means.

Q As you read those words no longer a player, do you connect that in any way to limiting your role concerning Sarah Aronson?

A I could see that, sure.

Q Okay. By June 16, 2009, had your role with respect to Sarah Aronson been limited?

MR. BIXENSTINE: You mean in any way?

MR. GORDILLO: Right.

MR. BIXENSTINE: Okay.

A I suppose it's possible. I don't -- there was a point where I would say I voluntarily had a limited -- some limitation in my involvement with her, but I don't know that it was on that date.

Q When you say voluntarily limited, are you talking

about something other than your decision not to have your name or her certificate?

A Well, the filling out of the six month Triple C Report from January of '09 to June of '09, for that six-month period, when the report was filled out and she was deemed satisfactory for that, the program's decision was to give her satisfactory, so by all rights with the evidence that we had for that time period and things that I personally had collected, if that was not enough for our program to decide she was unsatisfactory, then in my guesstimation -- and I respected the decision of our department, our program to give her the satisfactory, I just disagreed with that decision personally.

So at that point, I couldn't foresee anything that would occur in July and August that just wouldn't -- unless it was so egregious it was self-declaring, it looked to me like she was on her way to graduating. So I did all of my -- what I would consider my fiduciary responsibilities as a program director in collecting all of her case log information and all of her -- you know, all of the supporting information and documentation that was required to be supplied for her training. But I don't believe -- I don't believe or I don't recall if

I worked with her clinically anymore, and I don't know if there was some effort -- I don't recall if there was some effort to not have me --

MR. BIXENSTINE: Excuse me. I have to get that, because I'm the only guy around.

- - - -

(Thereupon, a recess was had.)

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(Thereupon, record read by Notary.)

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A -- scheduled with her, and I may have even -- I might have requested to not work with her. I can't recall if I did or not, but from my recollection, I don't believe we worked together clinically.

Q Do you believe that Doctor Shuck had given you any instructions before June 16, 2009 to limit your role with respect to Sarah Aronson?

A He may have. I respect Doctor Shuck's opinions and advice, and he may have generally said something that I might have surmised it to limit my involvement with Doctor Aronson, but I don't remember specifically having that kind of a conversation.

I don't think we ever had a face-to-face meeting stating anything like that, and I remember with

Doctor Shuck, I have talked to him on the phone a lot to ask for his advice on issues in dealing with Doctor Aronson, but I can't remember the exact timeframe, either, if he did allude to something like that.

But I remember at some point when our program decided that we were going to complete her six-month satisfactory and essentially then she'd be graduating in August, I remember -- and I don't know if I requested not to work with her because I felt if I give -- my personal work ethic is that every case that I do, I evaluate each and every case and each and every resident, and by giving more negative feedback, I don't think would -- there was no point to it, from my opinion, once our program decided we were going to graduate her. And I'd given my opinions about her and I submitted my evidence to our program, and my opinion was if they felt that overall with this in the context of everything that she was satisfactory, there's no point to me continuing to work with her, so I might have limited my role in either not working with her or she wasn't -- I don't remember what her schedule was at that point in time.

Q Doctor Shuck testified to the effect that he believed that you were emotional in connection with your

dealing with Sarah Aronson and perhaps not sufficiently subjective.

MR. BIXENSTINE: Objection. Go ahead.

Q Do you disagree with him?

A Yes.

Q He testified that he told you that he thought that that was the case and that in the context of the conversation told you that's why you ought to be limited in your role.

MR. BIXENSTINE: Objection.

Q Do you disagree with his testimony?

A You had two points.

Q Fair enough. Let me be clear.

Do you disagree with his testimony that he told you -- whole thing -- he told you that he believed you were emotionally involved and not sufficiently objective and therefore ought to be limited in your role with respect to Sarah Aronson?

MR. BIXENSTINE: Objection.

A He may have said something to that effect. I don't recall it being -- I don't recall it being that way. I don't ever recall him specifically saying that he felt I was too emotional. But I do believe there was a possibility he said for me to limit my involvement

in the case. I don't remember the exact timeframe of that and there was a point where that's what I also felt I should do.

Q Doctor Nearman similarly testified that he made a decision to limit your role and conveyed that to you.

MR. BIXENSTINE: Objection.

Q Do you disagree that he conveyed that information to you?

A About the decision?

Q Yes. That he made that decision and told you about it.

MR. BIXENSTINE: Objection.

A I suppose he might have felt he made some type of decision like that, but I believe the decision was mine.

Q Did he tell you he had made such a decision?

A I don't recall him saying that.

Q And you disagree with his testimony that he did tell you that?

MR. BIXENSTINE: Objection.

A I don't remember him saying that he decided something. I remember me deciding to limit my involvement with Doctor Aronson because my -- even though I respected what our program's decision was, I disagreed with it, so I felt that I should limit my

involvement. But that was my decision. He may feel he influenced that or he made his own decision about that or took credit for that. I don't remember him ever saying he's decided that. I don't know what that even means, because the only way I could see that that would be the case is Doctor Nearman many times makes out the schedule on assignments, so he may have decided not to schedule me working with Sarah. I could see how that would be consistent, but I don't remember any discussion of him saying he decided that my involvement was going to be limited.

Q The Clinical Evaluation Report is the result of a conclusion made by the Clinical Competency Committee; is that right.

A The Triple C Report, you're talking about?

Q Yes.

A Yes.

Q Who was on the Clinical Competence Committee in July of 2009?

A In July of 2009?

Q Yes.

A I believe it was Doctor Nearman, Doctor Norcia, and myself.

Q Did that committee meet to discuss how the ratings were going to be submitted on the reports?

A I will say yes.
Q And did you have a committee meeting with Doctors Nearman and Norcia to discuss rating Sarah Aronson's performance?
A I know that we did have a meeting -- I don't remember exactly when it was -- because we had to discuss how we were going to fill out this Clinical Competency Report.
Q Did you participate during that meeting?
A I would say I did.
Q Do you recall what Doctor Norcia's opinion was about whether Sarah Aronson's performance should be rated satisfactory or unsatisfactory?
A Well, I don't know what his specific opinion was. I remember he was weighing the positive things about rating satisfactory and the negative things that would support rating unsatisfactory. I remember he had some feelings about what he thought about both things, but the end result or the conclusion was that Doctor Aronson was rated satisfactory.
Q Do you recall whether Doctor Nearman's opinion was about whether she should be rated satisfactory or unsatisfactory?
A Yes. He also felt she should be rated satisfactory.
Q During that committee meeting, did you voice your

disagreement?
A Yes.
Q How long did the committee meeting discussion about Sarah Aronson last?
A I don't have a recollection of the actual time because it's hard for me to know exactly without looking at a calendar and putting it into context because we have had so many meetings, but I don't think it was -- I don't think it was a very long meeting.
Q Were the three of you the Clinical Competence Committee in January of 2009?
A Yes.
Q So the three of you as a committee would have been responsible for the reports that went out for the period ending in December of 2008, right?
MR. BIXENSTINE: Greg, are you starting a new topic? If you are --
MR. GORDILLO: Yes. I'm about to shift.
MR. BIXENSTINE: When you shift, can we take a quick break?
MR. GORDILLO: Sure.
A Is your question were the three of us the Clinical Competency Committee as of January of 2009?

Q Yes.
A Yes.
Q So that committee was responsible for completing the reports reflecting performance of the residents for the period of July through December of 2008, right?
A Well, the actual process, the committee meets, but Doctor Norcia is really the one that -- he's the official program director's signature. He's the one that actually filled out the report.
Q But it's based on the recommendation of the committee?
A Sure.
Q That's my question. The three of you comprised the committee that made recommendations about the evaluation of the residents for the period that ended December of 2008, right?
A That's correct.

MR. GORDILLO: Okay. Let's take a break.

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(Thereupon, a recess was had.)

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MR. GORDILLO: Back on the record. Could you restate the last question and answer, please?

- - - -

(Thereupon, record read by Notary.)

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Q (By Mr. Gordillo) So did the committee also meet to discuss as a committee what evaluation would be provided regarding Sarah Aronson for the period that ended in December of 2008?

A For the period -- let's see. December 2008. Are you talking about the period she got an unsatisfactory?

Q Yes.

A I'm not sure I understand your question.

Did they talk about which evaluations -- we took her evaluations to evaluate her for that period of time.

Q Did you, Doctor Norcia, and Doctor Nearman have a meeting during which you discussed what recommendation to make about Sarah Aronson's performance for the period ending December 2008?

A Yes.

Q Do you recall when that meeting occurred?

A I don't recall when it occurred.

Q How long did it last?

A I don't recall.

Q Did you discuss any other residents during that meeting?

A I doubt it.
Q Tell me what you recall in substance of the deliberation that went on during that meeting.
A The way we generally do it and the way we did it in this instance, we went down through the Triple C, the ABA Clinical Competency Report, and we go down through all of the different check boxes and look at each individual item in essential attributes and all the different categories and we see if we would rate it satisfactory or unsatisfactory.
Q And in her case, there was at least one category in which she was rated unsatisfactory, right?
A There were three categories.
Q Was there any disagreement among the three of you about whether she should be rated unsatisfactory in any of the categories?
A For the period from July of 2008 to through December of 2008, there was no disagreement among the three of us about how she should be rated for her Triple C Report.
Q She was rated unsatisfactory in the category of Essential Attributes; is that right?
A Yes.
Q And with respect to Essential Attributes, was there any discussion about whether to rate her satisfactory

or unsatisfactory?

A Essential Attributes is a category. It's not rated satisfactory or unsatisfactory.

Q Okay. What were the three criteria for which she was rated unsatisfactory?

A The three criteria?

Q The ACGME -- the three of the six, right? There are six?

A I'd have to look at the Clinical Competency Report, but there's a section called Essential Attributes, and there's about four or five questions under that. And then there are different areas, and I don't recall, but I think they're all related to the six core competencies, so there may be seven areas, the essential attributes, and then the six core competencies. I think they parallel the six core competencies, also. And she had a question under essential attributes under professionalism and patient care that were listed as unsatisfactory.

Q And did that correspond to any particular competencies?

A Like I said, essential attributes is not a core competency, but professionalism and patient care are two of the six.

Q Was she rated unsatisfactory in professionalism?

A There was a question under professionalism which she got a rating of unsatisfactory.
Q And under patient care, was there an unsatisfactory rating?
A There was.
Q And what other unsatisfactory rating did she receive?
A And there was a question under essential attributes, which is not a core competency.
Q Okay. And as each of those three questions were answered with an unsatisfactory remark, was there any disagreement or discussion among the committee members before concluding that she should be recommended as unsatisfactory?
A We did discuss --
MR. BIXENSTINE: Let me raise an objection. He answered the disagreement part.
A I don't know that we disagreed. We discussed it.
Q It was a compound question.
So is there any reason for not informing the residents about who the members of the Clinical Competence Committee are?
A I don't understand your question.
Q Is there reason not to inform the residents who the members of the Clinical Competence Committee are?

A I can't think of any.
Q It's not a published list of committee members, right?
A I don't think we publish it anywhere, no.

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(Thereupon, Exhibit 27 was marked for the purpose of identification.)

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Q (By Mr. Gordillo) David, you're being handed a document being marked as Exhibit 27. Please take all the time you'd like to look it over and let me know when you've had an adequate opportunity to review it.
A Okay. I believe I've read it.
Q The top of this email string from Kitty Coneglio -- is it Coneglio?
A Kitty Coneglio.
Q -- to you and Doctor Aronson. Do you see that?
A I see that.
Q And you can tell from the string that Doctor Aronson is asking who chairs the Clinical Competence Committee and who sits on it, right?
A Yes.
Q And eventually the question was referred to you, right?
A Based on this document?

Q Yes.
A That's not my conclusion.
Q Well, at the top, Kitty writes to Doctor Aronson that she spoke with Chris -- assuming that's Christina Adamovich --
A Yes.
Q -- and she said she referred your question to Doctor Wallace.
A Yes. That Kitty said that Chris referred that to me, yes.
Q Yes. Do you recall having the question referred to you?
A I believe Christine asked me that, yes.
Q And was it accurate that your response was that you plan to address this with Doctor Aronson at your meeting?
A Yes. I think that's probably accurate.
Q Why would you have been reluctant just to send her an email back with the three names?
A Because if anybody -- I would say that pretty much all the residents know that I do very little email correspondence. I get hundreds of emails, literally hundreds, and for some things that may be adequate, but I do very little email responses because my personal opinion is that email is good for

notification of things, but it can be very inadequate many times for a lot of different things.

And as this email states, and since Doctor Aronson was included in this email, it states that this was planned to be addressed when we met with her. I figured that was the concluding response that she became aware of, so there was no point for me to email her, and I did not.

Q When you met with her, did you tell her who was on the Clinical Competence Committee?

A When?

Q The meeting that's referred here.

A I don't know what meeting that is.

Q Let me rephrase that.

It's accurate that you indicated you were planning to address the Clinical Competence Committee at your meeting; is that right? I'm reading right on the email.

A Could you say that again?

Q Yes. I'm reading from the top email here where Chris said she referred the question to you and that you plan to address this with Doctor Aronson at your meeting?

A Yes.

Q Did you have that meeting?

A I don't know what -- let's see. I don't know what meeting that -- well, I'll say that my reading this, the intent of what it is was at our next meeting, this could be addressed. That's what the intent of this was. I don't know when our next scheduled or planned or when we met next. I don't recall when our next meeting was.

Q Did you ever tell her who was on the Clinical Competence Committee?

A I don't recall if I did or not. I don't think -- I don't recall her ever asking me.

Q Well, you got the question from Chris, right?

A Christine said she wanted to know, that Doctor Aronson wanted to know, and I told Christine that at our next meeting, we could discuss that. It would be a very easy discussion. When we met next, I don't know if the topic was ever brought up. And since Doctor Aronson wanted to know that information, I didn't inherently bring it up at our next meeting, so I figured if she was notified here, that our next meeting I would have that information.

Q You did know that she wanted to know who the Clinical Competence Committee was, right?

A Yes.

Q And you never told her who it was, did you?

A I don't believe I did.
Q Did you have any discussions with Doctor Norcia about revealing who was on the Clinical Competence Committee to Doctor Aronson?
A Revealing it to her?
Q Yes.
A It's nothing that's confidential, no.
Q No, you had no discussions with Doctor Norcia about telling Doctor Aronson who was on the Clinical Competence Committee?
A Well, I don't recall specifically having a discussion with Doctor Norcia about revealing who's on the Clinical Competency Committee. I may have said that Doctor Aronson wants know who's on the Competency Committee, but I don't think I ever had a discussion about revealing it. It's not a secret.
Q But you didn't tell her, did you?
A She didn't ask.

MR. BIXENSTINE: Objection. Asked and answered.

Q Did you ever have a discussion with Doctor Nearman about telling Doctor Aronson who was on the Clinical Competence Committee?
A I don't recall having that type of discussion with Doctor Nearman.

Q By May of 2009, did you know that Doctor Aronson was repeatedly seeking an appeal of the unsatisfactory evaluation that she had received?

MR. BIXENSTINE: Objection. Go ahead.

A I don't know because I don't think that's an appealable -- I don't know that there's an appeal for that.

Q I wasn't asking you whether it could be appealed. My question was whether you knew she was trying to get an appeal?

A She didn't ask me for an appeal. She never -- I don't recall -- I don't recall what forum I would have been aware of that. I know we had talked in the meetings with her, and I'm trying to think when our last meeting was. She wanted to know about the appeal process. We had had many discussions about that, but what we related to her were the options that she had, which would include something that's appealable or not, and she chose to go a route that wasn't appealable, so I don't know of anything I can say in May, or whenever you said, about her attempting to have an appeal.

Q I'm going to show you a document that was previously marked as Exhibit 1, and as always, take all the time

you'd like to look it over and let me know when you've had an adequate opportunity to review it.

A I believe I've reviewed this.

Q You're familiar with the document?

A Yes.

Q That's your signature at the bottom?

A It is.

Q This was the letter that you and Doctor Norcia sent to Doctor Aronson to inform her about her unsatisfactory evaluation, right?

A Yes.

Q Were you part of the decision-making process that resulted in the conclusion that she would be required to remediate for an additional six-month period?

A I was part of the process.

Q And did you agree with that recommendation?

A That she had to do an additional six months?

Q Yes.

A Yes.

Q As remediation.

A I'm not sure the term remediation, in what context, but in this context, I'd say yes.

Q What other context would there be?

A Well, I know -- I don't have the actual documents with me, but there are two documents that the

Graduate Medical Education Office has available for residents, and one relates to remediation and one relates to discipline, and I'm not sure exactly which one of those there are, but in the context of this, I would say she had to do six months of remediation that I agreed to.

Q I'm going to hand you a document that was previously marked as Exhibit 14. See if that helps you out some.

A Is there any part?

Q Yes. Why don't you look at Page 10 of that document?

MR. BIXENSTINE: I'm sorry? Which exhibit?

MR. GORDILLO: Page 10 of Exhibit 14.

Q (By Mr. Gordillo) This document was previously identified as an excerpt from the Resident' and Fellows' Manual, and I turned you to the attention of the portion that deals with remediation. Do you see that?

A I do.

Q Is this the document and the remediation you were talking about just a moment ago?

A This is not what remediation is from this letter.

Q That's what I want to know about.

A Yes.
Q How is remediation that's referred to in the letter that is Exhibit 1 different from remediation that you're looking at in Exhibit 14?
A Well, I guess, you know, reading all of this, this is partially out of context, that has things that I can see, like HR-85, and things in there, which may be consistent with this. But the remediation in this letter refers to the six-month incomplete unsatisfactory which would be corrected by a six month of satisfactory to follow. That's what this six month remediation is. I'm not sure if it's consistent with this just from a brief glancing at it. I think it might be consistent with this, but there's a lot of information here that -- I don't know that -- I don't think that -- well, I think it's probably consistent, but I haven't read all of this to analyze everything, but when I see referral to Employee Assistance HR-85, we did -- we implemented that policy in the EAP Analysis of the Tier 1 referral, so I suspect that this is consistent, but the remediation in this letter is related to the six months unsatisfactory that would need to be repeated.
Q You had testified a moment ago that you weren't sure about the context of remediation; is that accurate?

A Well, the context that you were referring to about remediation. I knew about the context that I was referring to in this letter.

Q So --

A There's many different contexts, though, that remediation falls under.

Q And specifically you mentioned two different contexts?

A I think I mentioned there's two different forms our hospital has, and I don't know which one talks about remediation, if either of them do.

Q Okay. I'm showing you one form that's been already identified as the Residents' and Fellows' Manual from the hospital.

A That's different than what I was talking about.

Q That's my question.

A Through the Graduate Medical Education on the UH website under Policy -- I think it's Policies and Procedures or Forms, I can't remember which, there are two forms, and I think one of those states about remediation, but without seeing which document it is, I can't say if it's consistent with one of those, because one, they're used in different contexts, and they have different implications, so I didn't know if you were referring to those documents.

But this letter, the six-month remediation refers specifically to the six months of unsatisfactory, to repeat that six months in order to gain satisfactory to bring the other six months unsatisfactory complete.

Q Let's look on Exhibit 14 where it addresses remediation.

A Okay.

Q In the first sentence it says: A remediation period is an opportunity for the resident to correct academic deficiencies and to develop and demonstrate appropriate levels of proficiency for patient care and advancement in the program.

Did I read that correctly?

A Yes.

Q Is that what we're talking about in Exhibit 1?

A I would say that at least part of that statement seems like it's very applicable.

Q Which part appears applicable?

A The part about demonstrating appropriate levels of proficiency for patient care.

Q Okay.

A I'd say that's definitely applicable. Advancement in the program, without this form of remediation, a resident cannot complete the program ending on an

unsatisfactory, so I'd say that both of those definitely fall within the definition that would be consistent with this letter in Exhibit 1.

MR. GORDILLO: Would you read that answer again?

- - - -

(Thereupon, record read by Notary.)

- - - -

Q (By Mr. Gordillo) Is there any part of that first sentence that is not applicable to the reference of remediation in Exhibit 1?

A The only question I have is the use of ands versus ors. A remediation period is an opportunity for the resident to correct academic deficiencies and -- I'm not sure if that should be and or or -- to develop and/or demonstrate appropriate levels. It's not necessary that someone has to do all of those, but at least part of those I think fall within the context of when we used remediation here.

I don't think, for instance, Doctor Aronson had -- that I can think of at this time -- academic deficiencies. I don't think she did. So if you use the word and, I don't think I agree that's part of what needs to be remediated.

Q So the letter that is Exhibit 1 is not intended to be

addressing academic deficiencies; is that right?

A I don't think it does, no.

Q And on the bottom of Exhibit 1, there's an indication that Christine Adamovich will assist you with setting up a time to meet and discuss the remedial program plan. Do you see that?

A I do.

Q Who was supposed to design the remedial program plan?

A Well, Doctor Norcia, Doctor Aronson, and I, the three of us did.

Q You did?

A Yes, we did.

Q Okay. And did you then give the plan to Christine Adamovich?

A Well, Christine is the Residency Education Coordinator and she's the person that keeps all of our documents, I would say, in, for instance, Doctor Aronson's file. So I suspect that we gave the copy of that to Christine. I suspect she had a copy of it.

Q So there was a document that was the remedial program plan that you created for Doctor Aronson?

A Yes.

Q And you created that document with Doctor Aronson?

A Yes. She signed it.

Q When drafting this letter that is Exhibit 1, did you participate in the drafting of it?

A Yes, I did.

Q Okay. Who else, if anyone, worked on drafting this letter?

A Well, Doctor Norcia and I, I believe, primarily drafted this letter. I don't recall, because there was at some point when our hospital Legal Department was reviewing all of our documents and letters -- I don't recall, although I think that either the Legal Department or Doctor Shuck might have reviewed it before we finalized it.

But I believe Doctor Shuck or the hospital Legal. I don't remember when the hospital Legal became involved with this, but there was a point where any official documents, our hospital Legal would look at.

Q What was the thought process that went into deciding that an additional six-month period was necessary for remediation?

A Well, when a resident performs unsatisfactorily, then depending on what it was that was unsatisfactory, it has to be corrected.

MR. BIXENSTINE: I think your focus is on the duration. I'm just stepping in. Maybe I should shut up. You're

asking six months?

MR. GORDILLO: He's fine. More generally.

MR. BIXENSTINE: Good enough.

Q (By Mr. Gordillo) One of the three categories that were identified as unsatisfactory was professionalism, right?

A Yes.

Q And specifically it was that you told Doctor Aronson she had failed to carry out her professional responsibility of notifying the Residency Program directors that she was taking a prescribed medication that could impair her judgment and/or job performance as required by hospital policy, right?

A Yes.

Q Did Doctor Norcia at some point suggest that that item should not be included in this letter?

A In which letter?

Q Exhibit 1.

A Did he suggest -- I'm sorry?

Q -- that it should not be identified as a unsatisfactory category in the letter.

A I don't think he suggested it should not be included in the letter. I remember he said that Doctor Aronson was concerned about having it in the letter,

but I don't know that he suggested it not be in the letter.

Q Did he ever say that the issue of professionalism should not be reported to the ABA?

A I don't think Doctor Norcia would have a discussion like that with me because, I mean, if something -- let's see. Report to the ABA. Yes. So that would be under the Triple C Report that goes to the ABA, so I don't think -- you know, it's not a reportable thing, so I don't think there's any reason to not report it.

Q Let me untangle that one a minute.

MR. BIXENSTINE: He just wanted to know whether he told you that. That's all. That was his focus.

A No. I don't believe he did.

Q What was Doctor Aronson to do in an additional six-month period to remediate her professionalism?

A On February 4th of 2009, we drafted her plan. I don't have all the details, but it's in that document.

Q Well, if the problem was that she had failed to disclose her use of a prescribed medicine and she subsequently disclosed it, is there anything left for her to do to remediate her professionalism?

A Well, I don't know that it's that concrete. She has to demonstrate on-going continual professionalism. If someone doesn't disclose something, once it's disclosed, I don't know that you can specifically figure out how to get it undisclosed to disclose it again, or something. So I don't know that there's -- I don't think it's that concrete that you have -- you know, it was just something that was unprofessional, but every six months, professionalism, those questions related to professionalism, have to be checked satisfactory, and in the next six-month period if those questions can be answered satisfactorily, we just have to go with the information we have at the time. So even if someone does something that's unprofessional, if they demonstrate on-going continual professionalism and don't demonstrate any more unprofessional behavior, then it would be considered satisfactory.

Q Why did she need another six months to do it?

A Because the ABA -- if you answer any one question unsatisfactory, the whole six-month reporting period gets unsatisfactory. In order to get satisfactory credit for those six months, then you have to complete the subsequent six months as being satisfactory.

Q When did Doctor Aronson's performance reveal to you that she was unable to demonstrate the ability to react to stressful situations in an appropriate manner as reflected by the letter that is Exhibit 1?

A I would have to review her evaluations in order to answer that question.

Q Okay. So is it fair to say that if she did through her performance show that she was unable to demonstrate that ability, it would be reflected in her performance evaluations?

A Possibly.

Q Well, you just said you'd have to look at her performance evaluations.

A Well, there are other things besides her written evaluations.

Q Other than her performance evaluations, what evidence comes to your mind to show that she was unable to demonstrate the ability to react to stressful situations in an appropriate manner as reflected by this January 7th letter?

A When you say performance evaluations, are you talking about my evaluations, written evaluations?

Q Whenever evaluations you were talking about when you said you'd have to look at the evaluations.

A Well, I would say that it's based upon resident and

faculty evaluations, and -- resident, faculty, and staff evaluations. I'd say that's --

Q Were there any evaluations of her performance in the month of December that would demonstrate that she was unable to react to stressful situations in an appropriate manner?

A When was that?

Q December of 2008.

A I don't recall what she was doing in December of 2008. I don't know what rotation she was on.

Q That's not my question. My question is: Do you recall?

A I don't recall.

Q To your knowledge, do you know of any evaluations showing that she was unable to demonstrate the ability to react to stressful situations in an appropriate manner in December of 2008?

A Without looking at her evaluations, I don't recall.

Q Okay. And do you know of any evidence that she was unable to demonstrate the ability to react to stressful situations in an appropriate manner in November of 2008?

A I don't recall.

Q Do you know of any evidence that in December of 2008, Doctor Aronson failed to demonstrate her ability to

recognize and respond appropriately to significant changes in the anesthetic course?

A I don't recall.

Q Do you know of any evidence that would show that in November of 2008, Doctor Aronson failed to demonstrate the ability to recognize and respond appropriately to significant changes in the anesthetic course?

A I don't recall.

Q Did you realize when sending out this letter of January 7, 2009 that Doctor Aronson had two more months left on her scheduled residency program?

A Let's see. She had -- on January 7th when she first enrolled in our program on January 7th, she would have had less than two months.

Q Right. She was scheduled to complete at the end of February 2009, right?

A That's correct.

Q Did you have any discussion with Doctor Norcia or Doctor Nearman about whether you believed that Doctor Aronson could demonstrate satisfactory performance in the time remaining between January 7th and the end of February 2009?

A Could you repeat that question again?

MR. GORDILLO: Go ahead and read it

back.

- - - -

(Thereupon, record read by Notary.)

- - - -

A I don't think we ever would have had that discussion. It's, I guess, irrelevant, on January 7.

Q Well, did you have that discussion at the time of recommending that she should be found unsatisfactory in her performance for the period ending December 2008?

A Again, it's irrelevant. If she got an unsatisfactory from July of 2008 to December of 2008, she would have to repeat six months. If she didn't, there would be no question about her ability to remediate. There's nothing to remediate.

Q Is your answer to my question no?

A Depends on -- if you could read the question again?

- - - -

(Thereupon, record read by Notary.)

- - - -

A It's --

MR. BIXENSTINE: He just wants to know whether it happened or not, simple as that.

A No, we didn't.

MR. GORDILLO: Right.

MR. BIXENSTINE: I hope you're not offended that I spoke up.

MR. GORDILLO: No.

Q And the remediation that's referenced in the January 7th letter, was it your intent that that remediation would begin immediately?

A The remediation period, the way the Board reports, would be from January 1st through June 30th.

Q Okay. So your answer to my question is yes?

A Well, when you say begin immediately, that's prior to January 7th.

Q So the remediation period should have already begun?

A Until you give someone an unsatisfactory -- you have to give someone an unsatisfactory, and then it's retroactive to the beginning of that next six-month period.

Q Okay. Which would be January 1st of --

A That's correct.

Q So her remediation period would have began on January 1st 2009?

A That's correct.

Q And assuming that she completed the six-month period satisfactorily, it would have ended June 30th of 2009; is that right?

A No.
Q Okay. When would the six-month -- if it starts on January 1, 2009, when does the six-month period end?
A So what we're talking about is getting the six months of unsatisfactory, from January 1, 2009 to June 30th, she has to get six months satisfactory in order to get credit for the previous unsatisfactory six months. But she was already scheduled for January and February, and her remediation plan that was outlined in the February 4th plan was six months that the three of us discussed that she needed to do from March through August.
Q So she had eight months of remediation?
A Well, there's two different considerations. In order for her to get credit for the six months, she has to follow by another six months of satisfactory for the previous six months unsatisfactory. She was already scheduled for January and February because we have to report by January, and in February, we made her remediation plan, and the plan was a six-month period that would start from March 1st through August.
Q What was she doing from January 1st to March relative to remediation?
A Well, if you're talking about the remediation portion to get the six months of unsatisfactory credit

converted to six months satisfactory, she was doing her regular clinical duties.

Q Beginning January 1st?

A Beginning January 1st.

Q And ending June 30th?

A That's correct. That's the ABA requirement.

Q So at the point of June 30th, her reporting period for that six months had ended, right?

A June 30th of 2009?

Q Right.

A Her reporting period for the ABA had ended, right.

Q And if she was rated satisfactory for that period, she would then also have been treated as satisfactory for the prior period, correct?

A She would have brought the unsatisfactory to satisfactory, yes.

Q So as of June 30, 2009, she did get rated satisfactory for that period, right?

A She did.

Q And so at that point, she had a satisfactory rating for the first part of 2009 and the last part of 2008, correct?

A That's correct.

Q And that would have been 36 months of residency training, correct?

MR. BIXENSTINE: You mean 36 months of satisfactory?

MR. GORDILLO: Yes. I'm sorry. 36 months of satisfactory.

A That's not correct.

Q Really?

A If you have a piece of paper, I can tell you what it would be.

Q Is it more than 36 months?

A I think so.

Q Okay. It's at least 36 months?

A Yes.

Q And you're familiar with the in-training exams?

A I am.

Q Why are they given?

A It's a -- up until about 2008, it was a preview to the actual written Board exam, and it gives the resident the experience to take the written exam, which is one of the Board's requirements to get Board certified.

Q And the scores on the in-training exam, they are predictive of the likelihood of success or failure when taking the actual Board exam, right?

A There is some predictability -- there's a correlation of exam scores from the previous year, yes, from the

previous year to the next, based on the old Board results exams. But the actual examination process has changed, in -- I think it was 2008. It used to be given in July, and then the in-training exam changed to March, which was no longer in sync with the actual written exam.

MR. BIXENSTINE: Well, he just wants to know whether it's predictive.

A Well, it used to be. But I don't know that it's considered -- I haven't seen any results that say that it's predictive, but most likely there's a reasonable prediction for it.

Q At what point did it stop being predictive if it stopped being predictive?

A Well, there was a correlation. Around 2008 I think was the last -- I'm not sure if it's 2008, but I think 2008 is the last in-training exam that was done in July. That's when the written Board exam is. So you have a whole year from when you take the in-training to when you graduate for the traditional candidate so it was predictive.

Now it's given in March, so you don't have completely a year, so there's been more time to prepare for it, so you would think that someone would score higher on it, but there's less time to react to

it before you actually have to take it for real, which is now in August, so I don't know if the recent -- after 2008, I don't know if it's correlative or not.

Q As part of the evaluation process of residents, did you take into account their performance on the in-training examinations?

A Sure.

Q So you were familiar with what in-training examination scores would be predictive of success on the Board; is that right?

A I'm very familiar.

Q And so the in-training exams would provide a scaled score for the entire test, right?

A Yes.

Q And then also provide a breakdown by category, right?

A Well, I'm not sure what you mean by breakdown by category. There's a scaled score for the exam.

Q For the entire exam?

A Yes.

Q And then the results, they would inform the residents of how many questions were asked in a category and how many were answered correctly and how that rated by percentile?

A Sure, sure.

Q But it's the scaled score that ultimately would be most indicative of likely success or failure?

A That's correct.

Q In 2009, do you know what the break-off point was on the scaled score showing success or failure?

A Well, my experience with what the scaled score would be is roughly a scaled score of 32 is an equivocal pass, basically.

Q Okay.

- - - -

(Thereupon, Exhibit 28 was marked for the purpose of identification.)

- - - -

Q (By Mr. Gordillo) Now you've been handed a document marked as Exhibit 28.

Do you recognize the document?

A I do not.

Q Okay. Take all the time you'd like to look it over. I will represent to you it's the 2009 In-training Examination Personal Performance Report for Sarah Aronson.

A So I've basically seen this. I understand the context of what it's about. I have not seen this report.

Q Assuming that this is a genuine report and her scaled

score is 38, you would agree with me that that was predictive of her passing her actual certified test; is that right?

A Absolutely.

- - - -

(Thereupon, Exhibit 29 was marked for the purpose of identification.)

- - - -

Q (By Mr. Gordillo) Now you've been handed what's been marked as Exhibit 29, and again, I'll represent to you that this is similarly the report on Sarah Aronson's in-training examination from 2008, and as you look at that document, you see that her scaled score was 33.

A I do.

Q Did that score reflect a score predictive of passing the exam, the certified exam, had it been taken the following year?

A Do you know if this is a July or March exam? I think this was a July exam. Is that --

Q Yes.

A Yes. It would be just above or right around an equivocal pass.

Q Of course she's a second year at this point?

A Sure.

- - - -

(Thereupon, Exhibit 30 was marked for the purpose of identification.)

- - - -

Q (By Mr. Gordillo) Now you've been handed a document marked as Exhibit 30 and is like the last couple of exhibits you looked at. It's the 2007 performance report of Sarah Aronson's in-training examination, and you see that it has a scaled score of 34, and I'll ask you whether that's predictive of a pass?

MR. BIXENSTINE: Answer the question.

A That would be -- that would correlate with equivocal pass, sure.

MR. GORDILLO: Let's go off the record for a second, please.

- - - -

(Thereupon, a recess was had.)

- - - -

Q (By Mr. Gordillo) For the in-training exam, what's the scale range for scores, let's say, for 2009?

A I think someone could potentially have the low score of a zero, I believe, although I've never seen that, and the high, I think it goes at least 50. I'm not sure what the high end is.

Q You were responsible for scheduling the rotations, right, in terms of the residents?
A That's a generally true statement.
Q Did you have responsibility for making sure that residents were scheduled within the duty hours restrictions imposed by the ACGME?
A I had partial responsibility for that.
Q With whom did you share that responsibility?
A The residents.
Q And to the extent you had responsibility for it, what did you have to do to exercise your duties?
A Well, when we made the curriculum and the rotations -- the curriculum for the rotations, we geared them so that the clinical hours would abide by the duty hour rules, and the didactics were scheduled so that duty hour rules could be observed. And then there were certain didactics which residents were required to not attend because they were post-call and wouldn't attend.
Q What did you do to make sure that the residents were in compliance with the duty hour restrictions?
A Well, I would say that I required them to follow them. I also would oversee -- like, when we would make call schedules, and things like that, I would oversee some of that to make sure that they were not

over.

If there was questions about a duty hours and residents' call, and those kinds of considerations, I would say most all of the time I would get called or paged, and I also made myself available by cell phone and pager virtually every evening when residents would be doing late duty.

If faculty wanted to keep residents longer hours, they would consult with me about having the ten-hour separation. So I would say those are most of the things, along with the design of our program.

Q The ACGME recommends that call periods not be scheduled more than every third night, correct?

A On average.

Q And the average is over what period?

A Over a month's time.

Q Is it unusual -- you would be the one who would schedule the call periods, right?

A Well, in the general ORs and for obstetrics, which is sort of an operating room coverage service, the chief residents usually make the call schedule, and then I review those, and sometimes the chief resident, if they have problems making it, will confer with me before it's made, and we look at those types of call schedules.

Q What about in the SICU?
A In the SICU, I don't actually make the call schedules for the SICU, but I do review some of them and our head of ICU confers with me a lot to inquire about how to maintain duty hours.
Q In September and October of 2008, who was the head of ICU?
MR. BIXENSTINE: You mean the head resident?
MR. GORDILLO: The director.
MR. BIXENSTINE: Sorry.
A I think -- I'm not sure if Doctor Hacker was. I don't know when she took over. I think it might have been Doctor Hacker. I think it was Doctor Hacker. I don't know.
Q So would you and Doctor Hacker have been responsible for scheduling the call periods for the SICU in September and October of 2008?
A Well, there's something different about September that was very different than, I believe, any other month we had done call. We were instituting a night float system, and I think September was the month that we did that in, so I was privileged to become aware of the actual schedule because it was a schedule design that we had to do, and so for

September, I believe I was aware of that, and it's clearly spelled out what the hours are for that.

And in October, I think we went back to more of the traditional-type of staffing, so I believe I'm -- I believe I'm fairly aware of what was on October. I'd have to look at the actual schedule, but I would say I'm probably familiar with both of the schedules and maybe would know that information.

Q But who was responsible for making the schedules?

A I don't know.

Q It wasn't you?

A I don't make the assignments for the ICU. I make the assignments for who is in the ICU, but the ICU teams are set up. I don't make the detailed call schedule.

Q Okay. And who would be responsible for making sure that the schedules didn't violate ACGME duty hour restrictions?

A Well, I would say I take at least partial responsibility for that. I might rely on -- I might rely on the people that make the detailed schedule, but I'd say any -- and I've instructed all of our residents if there's a problem with it to inform me, but I would say that pretty much if there's any kind of problems, I get notified, so I would say I take at least partial responsibility.

Q I think you testified earlier that -- I'm summarizing -- but generally the responsibility for compliance with ACGME duty hour restrictions was shared between you and the residents; is that fair?

A At least, yes. I mean -- well, for instance, Doctor Norcia and I have sort of set up the curriculum. Our education committee sets up the long-term curriculum to make sure it abides by it. Doctor Nearman's had some input in how to staff things to abide by it. I'm not the only one, but I do accept responsibility.

Q What records, if any, exist to show whether the Anesthesiology Residency Program was in compliance with the duty hour restrictions?

A Well, I'd say I can think of at least two things. One is the actual schedules and the second is our residents fill out duty hour compliance forms.

Q Are there any other records?

A Not that I can think of.

Q Let me make sure I understand what you testified to a moment ago.

With respect to staffing the SICU, particularly in September and October of 2008, you would have been responsible for assigning who was going to be there, but someone else decided when they were going to be there; is that fair?

A So on a monthly basis, I say what residents will be assigned to the ICU service. The details of which day and who's on call which day is more micromanaged by the team, and I believe they have -- like, residents have requests that may have consideration for making the schedule and the -- whoever is the director -- there's a faculty that's in charge of it, and I can't remember at that time if Doctor Hacker was but --

Q In September and October of 2008, did you confer with Doctor Norcia about who would be working in the SICU among residents?

A Every month I make the resident assignments based on their global calendar, and I incorporate the individual assignments into a document. That gets incorporated into our electronic system. Many times I carbon copy that document to lots of people, so I may have given Doctor Norcia that or not. I'm sure at some point he would be aware of it. He practices in the ICU so he probably has some particular interest in that. But I don't -- I don't go out of my way to necessarily inform him unless it looks like we're going to have problems with having the full complement of residents assigned to the ICUs for any given month.

Q Do you recall that Doctor Aronson was assigned to the SICU rotations in September and October of 2008?

A I do.

Q Did you have any discussions with Doctor Norcia about that assignment?

A In what regards?

Q Any.

MR. BIXENSTINE: You mean the results of it or the scheduling?

MR. GORDILLO: The scheduling, making the assignment.

MR. BIXENSTINE: That's what I thought. Okay.

A I believe that that was just her long-term, 36-month assignment, so I don't think I would have had a discussion with him about her necessarily.

Q Did you confer with anyone about the scheduling that was assigned to her during those two months?

A About her assignment?

Q Yes.

A Not that I recall.

Q And let me be clear. Now I'm not talking about her assignment to the rotation but her actual day-to-day schedule.

A Yes. Usually the person that makes the schedule

doesn't contact me unless there's a problem that the resident has with that. For instance, if they want to take vacation or go to a meeting during ICU months, that's not -- the rule is you're not allowed to take it during ICU months because of the duty hours and the staffing. So if there's a question like a resident is presenting at a meeting, or something, which is sort of a conflict, sometimes they'll inquire to me about, do I have any other resources to staff, or something like that. But there's nothing that comes out in my mind that I recall at this time that anybody would have talked to me about her rotation. I believe she was just assigned to it as part of her 36-month initial curriculum, and that was her assignment.

Q In October of 2008, did you work in your capacity as a faculty member in the SICU?

A Not as a faculty covering the ICU.

Q Did you have opportunity to have personal observations of Doctor Aronson's work in the SICU in October of 2008?

A It's possible I could have had some observations, but not as a faculty supervising her from an ICU standpoint.

Q Did you have responsibilities for staffing the Acute

Pain Service rotation in November of 2008?

A There's a good likelihood I did.

Q And would your responsibilities with respect to staffing and scheduling be similar to those responsibilities you had concerning the SICU rotation?

A No. It would be different.

Q Okay. I was trying to cut it short. All right.

What were your responsibilities with respect to staffing the Acute Pain Service rotation in November of 2008?

A As a faculty, we have a faculty assigned every day to staff the Acute Pain Service. The block resident is assigned to the block rotation for the whole month. The block residents aren't allowed to take vacation during the whole month, so I have to make sure that they're present for the whole month, and then they do take some call, like a Friday and a Saturday call, for the whole month, so that on the weekends when they're not on call, they can be post-call from an operating room call standpoint. So I more directly see the assignments for the call schedule for the Acute Pain Service for the block resident, so I would have some oversight of that. But I don't oversee the call assignments for the ICU specifically. That's

how it's different.

Q Is it fair to say you have more direct interaction with the scheduling process in the Acute Pain Service rotation?

A Yes.

Q Did you work with anyone else to schedule the residents in the Acute Pain Service rotation for November of 2008?

A Well, I'm not sure exactly your question.

On the long-term schedule I make, I make the 36-month schedule roughly in the first two months of residency, and who's assigned to the block month, the Acute Pain Service month, is already set, so it's on the schedule. So unless someone wants to switch months with somebody, then I have to work with it, but I don't remember any changes in the schedule.

Q I'm talking about the day-to-day scheduling now. Let me make sure we're on the same page.

I thought your testimony before was that one of the differences between what you did with respect to SICU rotation and the Acute Pain Service rotation was you had more direct involvement with the scheduling.

A About the Friday and Saturday call, yes.

Q So my question is: Who else was responsible for the scheduling, the daily scheduling within that

rotation, the Acute Pain Service rotation, in November of 2009?

A The chief resident and I.

Q And the chief resident would have been whom?

A In what?

Q November of 2009.

A I believe it was Doctor McFarland.

Q And together it would be your responsibilities to make sure that the scheduling would not exceed ACGME duty hour requirements; is that right?

A Yes. I'd say that's true.

Q Did you work as a faculty member in the Acute Pain Service rotation in November of 2008?

A Probably.

Q And Sarah Aronson was assigned to that rotation in November of 2008, right?

A I don't know. I don't have her schedule in front of me.

Q Do you have any recollection of having personal observation of her work in November of 2008?

A November of 2008. I don't recall.

Q On October 14th of 2008, you had a meeting with Doctor Norcia and Sarah Aronson, right?

A October 14th? I'm trying to think which meeting that was. I may have.

Q Do you recall a meeting in October of 2008 during which you and Doctor Norcia discussed performance problems with Doctor Aronson?

A I don't at this time recall.

I think we did have a meeting in October. Yes. I think we did have a meeting in October of 2008.

Q Do you recall meeting with her to express your displeasure that you thought she was dumping work on other residents?

A I may have. But I know the term dumping is not in my vocabulary, so that might be a paraphrase.

Q Do you recall meeting with Doctor Norcia and Doctor Aronson in October of 2008 to discuss concerns about her lack of appropriately rapid response to events that occur in the OR?

A I don't know if it was at that meeting, but it could have been.

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(Thereupon, Exhibit 31 was marked for the purpose of identification.)

- - - -

Q (By Mr. Gordillo) You've been handed a document that's marked as Exhibit 31. Please take all the time you'd like to look it over and let me know when you've had an adequate opportunity to review it.

A Okay.
Q Do you recognize the document?
A I do.
Q Can you tell me what it is, please?
A It's a letter or memo to Doctor Aronson detailing some of the things that we discussed in our October 14, 2008 meeting and some of our concerns that we had and her response to some of the concerns.
Q And you signed this document, right?
A I did.
Q So as you look at this document now, does it refresh your memory about meeting with her on October 14th?
A Yes. This was a follow-up to that meeting.
Q Okay.
A Subsequent meeting to that meeting.
Q And with your memory refreshed about the October 14th meeting, can you tell me what topics were discussed at the October 14th meeting?
A Multiple unsatisfactory evaluations and Doctor Aronson's lack of ability to identify problems.
Q Okay. Do you remember what unsatisfactory evaluations were presented to Doctor Aronson at that meeting?
A I don't recall.
Q Did you present any unsatisfactory evaluations to her

at that meeting?

A On October 14?

Q Yes.

A I don't recall.

Q Do you recall whether -- strike that. Let me rephrase it.

Were any written unsatisfactory evaluations presented to Doctor Aronson at the October 14th meeting?

A I don't recall.

MR. GORDILLO: Off the record.

- - - -

(Thereupon, a recess was had.)

- - - -

MR. GORDILLO: Back on the record. Do you want to read back the last question and answer, please?

- - - -

(Thereupon, record read by Notary.)

- - - -

(Thereupon, Exhibit 32 was marked for the purpose of identification.)

- - - -

Q (By Mr. Gordillo) David, you've been handed a document marked as Exhibit 32. Again, please take